

Referral for Ambulatory Mental Health and Addictions Services Interventional Psychiatry Program

Location: St. Michael's Hospital, 30 Bond Street, 17 Cardinal Carter South
Toronto, ON M5B 1W8
Phone: 416-864-5120
Fax: 416-864-5480

Referrals must be faxed to 416-864-5480. Referrals that are not faxed will not be accepted.

INFORMATION FOR REFERRING PROVIDERS:

- **A physician or nurse practitioner referral is required** (self-referral is not accepted)
- It is preferred that the referral comes from the treating psychiatrist or physician
- The referring physician **must accept care after patient has completed the time-limited treatments available in the clinic**
- This program is not catchment specific
- This referral form is for the Interventional Psychiatry Program only – for all other referrals, please use the general SMH referral form for Ambulatory Mental Health and Addictions Services, which can be found at stmichaelshospital.com

INFORMATION FOR YOUR PATIENT:

- Please ensure that your patient is aware that the referral is being made
- Please ensure that your patient is aware that services are time-limited and that general psychiatric care is not offered
- Our intake team will make two attempts to contact the patient and leave two voicemails, when consent is provided. If the patient cannot be reached, the referring provider will be notified. Please note that the number will appear as a blocked caller ID.
- Given SMH is a teaching hospital, your patient can expect to have residents or other learners involved in their care.
- Given SMH is an academic research hospital, your patient may be invited to participate in research opportunities. They do not need to accept.

PLEASE NOTE THE FOLLOWING CRITERIA:

These criteria are required to receive care from this clinic:

- a) Referring practitioner agrees to accept patient once psychiatric treatment is complete
- b) Patient accepts that treatment and services are time-limited
- c) Patient is 18 years of age or older
- d) Patient has tried at least one or more guideline concordant psychotropic medication trials and at least one or more guideline concordant psychotherapeutic trials

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REFERRING PHYSICIAN'S INFORMATION	
Physician's Name:	Billing #:
Family Doctor:	Specialist (specify):
Address:	Postal Code:
Tel:	Fax:
Email:	
Does your patient currently have a psychiatrist? Yes No Unknown	
I am the treating psychiatrist	
If you are not the treating psychiatrist, please indicate the name of the psychiatrist:	
First name:	Last name:
If you are not the treating psychiatrist, please confirm that the treating psychiatrist is aware of referral:	
Yes No N/A If no, explain why:	
If you are not the treating psychiatrist, please confirm if a referral has been made to a psychiatrist who can provide long-term care after treatment:	

PATIENT INFORMATION	
Consent to referral	Patient informed services are time-limited
Legal name: Last	First
Preferred name:	Gender:
Date of birth: Address:	Tel:
Postal code:	Mobile:
Health Card Number:	Version Code:
With another person: Yes No	
Consent to leave voicemail: Yes No	
If your patient would like to use email for appointment scheduling, indicate the following has been done:	
Reviewed SMH email consent with patient	Included signed consent with referral
Patient Email address:	

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REASON FOR REFERRAL (*):

Please indicate primary reason for referral, current symptoms, and provide details of previous treatments:

Please attach a list of current medication to the referral.

RISKS AND SAFETY CONCERNS

This information is used to optimally plan for the patient's first appointment and to ensure their safety and the safety of our staff.

RISK ISSUES	PRESENT		PAST		DETAILS
	Y	N	Y	N	
Legal Involvement					
Violent Behaviour					
Suicide Attempts/ Ideation					
Other Self Harm Behaviour					

The referring practitioner has reviewed the referral criteria on page one and confirms the client meets the criteria to receive care.

Initial: _____



Signature: _____

Date of referral: _____

Name (print): _____

Designation: _____

Please note that forms that are incomplete or not clearly printed will be returned.